Spring 1985

Update - Spring 1985

Loma Linda University Center for Christian Bioethics

ETHICS CENTER
Volume 1, Number 3 Spring, 1985

Update

250 ATTEND FIRST NATIONAL ETHICS CONFERENCE

Over 250 people attended the regular sessions of "Biomedical Ethics Today: Old Models and New," a conference sponsored by Loma Linda University's Ethics Center and the Hastings Center of New York on April 21 and 22 with financial assistance from the California Council for the Humanities. The audience for the Sunday evening discussion of ethical issues in organ transplantation swelled to approximately 1,500 persons. About ten percent of those who registered for the entire conference came from states other than California, some coming from places as far away as Rochester, New York and New Orleans, Louisiana. The majority of those who participated in the entire conference were physicians or nurses, but a number of dentists, lawyers, ministers, chaplains, welfare workers, and psychologists were also present.

The conference received favorable and frequent coverage from the news media that included extensive coverage of the Sunday evening discussion by one of the national television networks. A number of peaceful but vocal protestors of the alleged misuse of animals and humans in some medical experiments added to the session's aura of anticipation.

This first national ethics conference at Loma Linda focused on several contemporary issues including ethical problems in neonatology, death and dying, organ transplantation, allocating health care in the United States and in the third world, and the uses of living beings in therapy and research. Each of the sessions began with a major presentation from someone from either the Hastings Center or LLU's Ethics Center. A clinician and a scholar from one of the humanities then commented on the topic from his or her perspective. This was followed by questions and comments from the audience.

The formal evaluations submitted by those who attended the conference indicated that they were pleased with the quality of the presentations, the organization of the conference, and the facilities. The evaluations also encouraged the Ethics Center to provide more opportunities at subsequent conferences for attendees to become acquainted with each other and with their various viewpoints and to tailor the presentations even more closely to the practical needs of clinicians.

The staff of the Ethics Center is planning to publish the conference's major presentations in some way in the near future, though these plans have not yet been fully finalized. Extensive excerpts from the Sunday evening discussion of ethical issues in organ transplantation are available in the center section of this issue of UPDATE.

CAPRON TO DISCUSS "THE HIGH COST OF DYING"

Alexander M. Capron, Topping Professor of Law, Medicine, and Public Policy at the University of Southern California, will deliver a lecture on "The High Cost of Dying" at Loma Linda University Medical Center on October 9.

The Capron lecture will begin at noon in the Medical Center's A-level amphitheater when the monthly Medicine and Society Conferences resume following the summer vacation. Charles Teel, Jr., Chairman of LLU's Department of Christian Ethics and a specialist in questions of social justice, will respond to Professor Capron's presentation. The last 15 minutes of the hour-long program will be reserved for audience discussion to be moderated by James Walters. Attendance is open to all without admission charge. Funding for the monthly meetings is provided by The Wuchenich Foundation.

Before assuming his duties at the University of Southern California, Capron served for three years as the Executive Director of the President's Commission for Ethical Problems in Medicine and Biomedical and Behavioral Research. Before that he taught at Georgetown University, the University of Pennsylvania, Yale University, and the University of Connecticut. He has also served on the Board of Directors of the Hastings Center in New York and the American Society of Law and Medicine in Boston. In addition to the works published by the President's Commission, he is the author of two books, three major discussions in the **Encyclopedia of Bioethics,** and nearly 100 other scholarly articles.

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Letters to the Editor

Dear Editors:

I read the first issue from cover to cover. While I enjoyed it, I felt it was a bit subjective on the side of cross species transplants and the more utilitarian view of controversial medical practices. While I support fully continued research, I think we need better answers to the ethical questions that are being raised. As you know probably better than I, this whole question of medical ethics came into sharp focus at the Nuremberg war crimes trial in 1945-46. Growing out of that series of trials was the Nuremberg Code. The central provision of the Code holds that "the voluntary consent of the human subject is absolutely essential . . . the duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates . . . the experiment."

With adults that is not an ethical dilemma unless the adult is not capable, for whatever reasons, of understanding the issues and making an intelligent decision. However, for a baby that code provides little help. Consequently there is a pressing need to develop a more comprehensive ethic to guide us in these matters.

Also, while the larger good of society demands experimentation in the area of medical science, if some clear code of ethics is not developed, the issues will be left to the whim of the rich, the ambitious, and the opportunist.

John W. Fowler
Ohio

An Editorial

OUR TWOFOLD POTENTIAL

I developed a commitment to "present truth" from my early religious education. Formulations of truth will change, I was taught, as circumstances alter and as culture shifts. However, individuals, churches and societies are tempted to repeat old insights irrespective of new contexts. In the name of present truth, such complacence must be labeled debilitating—spiritually, yes, but also humanly. Reexamination is constant, says historic Adventism. According to an ancient sage, "The life which is unexamined is not worth living."

Society is now giving unprecedented reexamination to the health-care industry. Adventism has three compelling reasons for participating in this reexamination: (1) a heavy financial investment in health care, (2) a doctrinal commitment to holistic religion, and (3) a rich history of distinctively Adventist hospitals. Battle Creek Sanitarium in Michigan was founded in 1866—three years after the organization of the Seventh-day Adventist denomination. Today the church has over four million members and it operates a world-wide chain of 200 hospitals that create an annual revenue of some two billion dollars.

Many of the issues facing medicine and health-care today are conceptual, ethical, and ultimately religious. The formation of the humanistically-oriented Hastings Center, a bioethics think-tank near New York City, is noteworthy. The Roman Catholic tradition, rich in moral deliberation, fosters the Kennedy Institute of Ethics in Washington, D.C. LLU's Center for Christian Bioethics is a fledging; our challenges are great and our opportunities are many.

The Loma Linda University Ethics Center's potential is twofold:

First, to facilitate Adventist thinking. Insightful commentary on the integral relationship of religion and health exists in Ellen White's writings, but new circumstances compel reformulation. In the 19th century, Adventists developed the sanitarium model of health-care. Today this model has largely yielded to the acute hospital concept. What distinctive mission—if any—should today's Adventist hospitals be serving? American health care is today, just as it was 100 years ago, undergoing radical revision. What is Adventism's vision? Are the church's traditional emphases on bodily health, human freedom and preventive medicine only personal counsel, or is there relevance to modern medical dilemmas: the right-to-die, abortion, and health-care delivery? The relationship of church teachings to clinical issues is not self-evident and application of these principles will require in-depth collaboration among church leaders, hospital administrators and theologians. The Ethics Center could serve as a catalyst to an exciting and uncharted Adventist future in health care.

Second, to enrich societal discussion. Most bioethics institutes unwittingly, and appropriately, presuppose the humane values of Western civilization—values derived largely from the Judeo-Christian tradition. LLU's Ethics Center is in fundamental agreement with these values and it is in a unique position to ponder them and to enhance them in light of the church's commitment to their wellspring: Judeo-Christianity. American bioethics is only as fertile as the insights emerging from a variety of thoughtful communites. Given the Adventist commitment to Biblical theology, Christian holism and human freedom, the Ethics Center can enrich the quality of society's bioethical discussion.

Innovating in the 20th century will take no less energy, stamina, and courage than did pioneering in the 19th. Are we—church, supporter, and ethicists—up to the challenge? The answer is now being formulated by our corporate response.

James Walters

REFLECTIONS REGARDING ORGAN TRANSPLANTATION

On Sunday evening, April 21, the Hastings Center's Arthur Caplan presented a public lecture on "Ethical Challenges of Organ Transplantation: Allografts, Xenografts, and Artificial Organs." The panel that responded to Doctor Caplan included Doctors Leonard Bailey, M.C. Theodore Mackett, Jack W. Provonsha, Richard Sheldon, Bruce Wilcox, and Charles Teel, Jr. of Loma Linda University, and Dan D. Rhoades of the School of Theology at Claremont. Alexander M. Capron, formerly of the President's Commission on Bioethics and now at the University of Southern California, was the moderator. The following edited excerpts indicate the friendly and frank tone of the evening's conversation. Audio cassettes of the entire session are available for a modest charge from Study Tapes, 1341 Pine Knoll, Redlands, California 92373. Video cassettes are available from the Loma Linda University Church, Loma Linda, California 92350.

Caplan: Tonight I want to say some things in general about organ transplantation, and then I'll comment on xenografts and the Baby Fae case. I'm putting the two topics together because I think they are closely related.

What progress has occurred in the organ transplant field? Last year in the United States there were something on the order of 6,000 kidneys transplanted. Last year 172 heart transplants were performed. Somewhere between 250 and 300 liver transplants were performed, and a variety of other tissues were transplanted.

The number of people awaiting kidney transplants may be as high as 22,000 or 25,000, since about 71,000 people are on dialysis machines. If the physical restrictions on heart transplants were relaxed, if people felt more confident about heart transplants in older and younger people or in patients with other complicating conditions, that number could grow to as high as 10,000. The harsh fact is that a big gap exists between supply and demand.

Who should pay for these procedures? It would cost about $200,000 to do a liver transplant at Pittsburg on a young child. A heart transplant at Stanford probably costs between $80,000 and $120,000, and a pancreas transplant $40,000 or $50,000 per procedure.

Who will decide who will get the scarce liver or kidney tissue? Some people say, "In America we have a system that doesn't ration." But in the transplant field that is not true. We have a rationing system in place which operates according to what I will refer to as a **green screen.** We use the ability-to-pay to decide who'll get access to certain forms of transplantation. At the University of Pittsburg, if you do not have in advance the $100,000 or $150,000 for a heart or liver transplant, you will not be put on the waiting list.

I would argue that if a transplant is known to be efficacious, if a patient wants it, and if by giving that transplant we don't distort services a community should provide to other people, we have an obligation to try to make sure that money is not a barrier to access.

I'm not going to recap the history of Baby Fae here at Loma Linda. But it seems to me that five questions arose in this case: (1) Did the researchers have a reasonable scientific basis for undertaking the experiment when they did? (2) Was the informed consent process adequate? (3) Is the existing system for regulating human experimentation regarding this kind of a xenograft adequate? (4) Was the institution correct in deciding to sequester the informed consent form and research protocol? And lastly, (5) Is it morally acceptable to use an animal in order to try to save human beings?

I'm going to get rid of the last question right away. My answer to that one is basically, "Yes, it is, if we know that we can benefit a human being by sacrificing an animal."

Was the scientific basis adequate? It was difficult to know, but there seemed to be very little independent assessment of the scientific basis for the experiment. Specialists from Montefiore and Stanford came in and looked at some of the immunological information. But those people quickly became involved as co-researchers in the project. Without independent assessment, without the ability of peers to comment critically, I think the scientific basis for the experiment was suspect.

What about informed consent? The National Institutes of Health sent a team out here in December and its report was available in March. I found it a very persuasive report in answering concerns about informed consent. It indicated that the parents seemed fully informed, that Dr. Bailey and his colleagues had spent many hours discussing the experiment with them, that full complete consent had been obtained. But I do criticize the informed consent process on the question of whether sufficient attention was given to the alternatives—either pursuing a human heart transplant from a cadaver source or surgical repair of the heart as a temporizing option. All options must be presented fully, zealously and fairly. It's not enough to say, "There are other alternatives, but we don't think they're going to work; we'd like you to think of the xenograft."

"I think the lesson that came out of the Baby Fae case is the need to be forthright, open, and honest; to disclose information." *Arthur Caplan*

This leads me to my major complaint: the question about sequestering information. The issue of keeping documents secret troubles me deeply. It's the thing that bothered me most about the experiment when I

commented about it from afar, and it stills bothers me today.

Loma Linda decided not to release the informed consent form at the time of the experiment, and not to release the research protocol which, to my knowledge, has not been made public to this day. That appears to have been a tactical mistake and a terrible blunder. I know from talking with Dick Sheldon and reading some of his comments that he believed that the best way to protect the researchers was to keep things secret. But I do not agree.

I believe that when you're operating in an area where you're making an innovative, pathfinding breakthrough, the public must understand exactly the protections afforded the subjects in the experiment, and the scientific rationale. You cannot do that unless you give access to those critical documents. Moreover, you cannot do that unless you are clear and forthright in fully disclosing the review process. Only later, in conversations with Dr. Provonsha and others at Loma Linda, did I myself learn how carefully this particular experiment was reviewed. That kind of information should not be kept secret. The public must be assured that not only is scientific progress being attempted; not only is a good-faith effort being made to help a dying child; not only is every effort being made to afford the parents of that child a full presentation of their options; but also that the experiment is being conducted according to the highest standards of human experimentation.

I think it is inevitable that we will have to turn to animal sources of tissue and organs for certain types of medical problems. I think we ought to do more in procuring human-cadaver organs and paying for them when we believe they can really help people. Most importantly, I think the lesson that came out of the Baby Fae case is the need to be forthright, open, and honest, to disclose information. I think many of Loma Linda's problems concerned the institution's decision to remain private when I think it would have been better and morally obligatory to have gone public.

Capron: I'm sorry Southern California didn't greet Dr. Caplan with sunshine. It's obvious his views are based on the notion that sunshine has a good effect on ethics.

"We weren't totally secretive about Baby Fae, but things we let out got distorted to the point of falsification. I don't know what to do about that." *Bruce Wilcox*

I hope that before he leaves we can give him some sunshine.

I'd like to begin with Dr. Leonard Bailey.

Bailey: Thank you very much, Dr. Capron. Dr. Caplan, you're not as bad as I thought you were, and we're not as bad as you think we are. I appreciate your erudite discussion tonight, and maybe we'll get to some of the answers.

Our project is predicated on a number of things. One factor is that uniformly lethal nature of the disease we're trying to address. Another is an absence of long-term data on the efficacy of palliation in this group. While I support what my associates in the East are doing in terms of palliation, that experience hasn't been duplicated well anywhere in the world, and still no long-term data are available. To suggest that palliation is somehow better than transplantation is fallacious. Also, there is a virtual absence of newborn heart donors—those of us in pediatrics understand the difficulties of making a diagnosis of brain death in this age group. When a baby gets to 8 or 10 months and has a large cardiomyopathy heart, you can extend the donor base to 2 and 3 year olds for even a small infant; but a newborn like Baby Fae has only so much space.

Wilcox: The issue of secrecy ranks high in what Art has had to say. The one thing that strikes me is the difficulty of getting correct information to the public. We weren't totally secretive about Baby Fae, but things we let out got distorted to the point of falsification. I don't know what to do about that. If an informed public can make decisions—and I hope they can—great. But how do we get the correct information to them?

Mackett: We've come full circle since the early sixties, when baboons were of great interest to several well-known surgeons. Recently in Britain I talked with Peter Morris, a transplant surgeon of some reknown. When I mentioned that we were contemplating a baboon heart transplant in the neonate, his face brightened. "By George, it'll work!" he said. In his own experience with immunosuppressants in the early sixties, an adult patient had survived 9 months on a functioning baboon kidney. He had never thought of doing something in the neonate.

Sheldon: On several occasions during the years I have been IRB Chairman at Loma Linda, I have had the opportunity to listen to Art lecture. On one occasion I walked out because his lecture so infuriated me. But tonight, once again, Art, I congratulate you approaching us with some kindness and some understanding.

I'd like to comment on the secrecy issue. At no time did we feel we were maintaining our documents in secret. These papers were to be released, as Bruce suggested, in a controlled manner through a trustworthy source. I have become somewhat critical not only of the Hastings Center, but also of PRIMR, Public Responsibility in Medicine and Research, because of their "ambulance chasing." We did not figure that these documents were secret; only that we would release them in a controlled manner to an organization that would handle them appropriately.

Capron: Well, besides not giving Dr. Caplan any sunshine, we've now decided he's an ambulance chaser—a poorly paid one!

Provonsha: I was Chairman of the Ethics Committee that reviewed Dr. Bailey's work. We felt satisfied that there was reason to think Baby Fae would be better off with the surgery than without it. My chief concern as an ethicist, however, has been conditioned by my reaction to the community of ethicists. It's true that ethicists at a distance did not have access to the information we had close at hand. It is also true that a fair number of them spoke as if they knew what they were talking about before they had the facts in hand. It seems to me there's an ethical question here. Ethicists have a right to ask questions, but until they have the facts they are ethically bound to limit themselves to asking questions rather than making positive statements.

Rhoades: It would ill behoove me to raise an issue about the use of animal tissue with the Seventh-day Adventist community when I eat animals and you do not. Obviously, I do not have a problem at that point. But on the question of secrecy, precisely for the reason Dr. Provonsha

raised, that others need to ask questions and have information, I would disagree with Richard Sheldon. I understand his position, but it seems to me that a primary concern of public policy should be to require all institutions to be forthcoming with such information so that responsible parties throughout the country can be looking over each other's shoulders to some extent. I know this is done in the long run, but it might have been helpful if a more "open" policy had been adopted to begin with.

"If society is willing to spend enormous sums defending this country, it seems reasonable to spend some money on transplantation." *Leonard Bailey*

Bailey: There truly is a shortage of human organs, and it probably is an issue of morality as to how recipients get their grafts. I've been appalled at the television hype surrounding some liver grafts.

I'd like to comment on whether or not it's worthwhile to do transplants, and on the idea of keeping some centralized data collection bank on these. First, I think transplants probably are worthwhile to society, whatever the costs. They provide some measure of hope that people wouldn't otherwise have. If society is willing to spend enormous sums defending this country, it seems reasonable to spend some money on transplantation.

The only issue I would take with the centralized data collection bank is that I wouldn't single out transplantation. In all areas of surgery and medicine the same thing can be said.

Wilcox: I can second the need for centralized data collection, but I think I'd better pass on the rest of the subject until I get my donor card.

Capron: I have one right here for you. Mine came with my new California driver's license, but I already had one so I didn't need it.

"I would second the idea of a required request, requiring those who deal with the situation—and its not pleasant oftentimes—to approach the family on the subject of organ harvest." *Theodore Mackett*

Mackett: Art, I'm interested in what I've seen as an evolution in your own ideas in regard to required requests. I remember a disclosure you gave on presumed consent, that practice followed at least in theory in many of the European countries where, if you're rendered brain dead, your organs are recovered without regard to the wishes of the deceased or the family.

I would second the idea of a required request, requiring those who deal with the situation—and it's not pleasant oftentimes—to approach the family on the subject of organ harvest.

Sheldon: One of my terrors is the pressure that will be placed on IRB's at the local level. I've just paid my income taxes and I hope I don't get as much government as I paid for. The government is no paragon of ethics. I see ahead of us an enormous amount of hard work with very little to indicate which direction we should go and how we should do it, whether we're on the governmental level or the local level. It doesn't make a bit of difference.

Provonsha: One of the most difficult ethical questions we face is learning how to see that everybody gets his fair share of what he deserves, of what he needs. When you start questioning a "green screen" method you also question the free enterprise system itself. I'd like to live in a classless society with everybody having an equivalent amount of money and food and housing and airplanes and all the other things we'd like to spread around. I don't know how to get such a society without sacrificing other things more valuable to me—that is, freedom, which is very high on my list of values. I have the suspicion that I may just have to wait until I get to heaven before we have a classless society without dictatorial restrictions and laws that take away some basic freedoms. How to balance freedom with the need to allocate fairly is something we must address. I don't have good answers for that yet.

Capron: I think Dr. Provonsha has raised an important concern that goes beyond transplantation. But the question has to be asked whether health care is different from airplanes and televisions and maybe even housing and food. We now speed about 11 percent of our gross national product on health care, but this means we have less to spend on other things. The question Dr. Caplan raises is, Do we find the use of dollars an acceptable rationing mechanism?

Rhoades: I find myself in strong disagreement with Dr.

"I've just paid my income taxes and I hope I don't get as much government as I paid for. The government is no paragon of ethics." *Richard Sheldon*

Caplan on part of his statement because it seems to me he approached the issue as an economist concerned with supply and demand, indicating that money shouldn't prevent more and more people having access to these transplants. This seems to be an artificial approach. The comments Alexander Capron just made point in a different direction. Possibly what we need is a careful assessment of the essential medical needs of our people and the dollars available, then allocate those resources to best utilize the dollars. This probably will require, whether we like it or not, public decisions and not just private, free decisions by individuals. It seems suspect to suggest that it's simply a supply-and-demand matter and that everybody ought to be able to have access—the more the better—when we aren't even beginning to meet basic medical needs.

Teel: I want to echo Dr. Provonsha that I don't know how to achieve a classless society. But I'm not certain I want to wait until heaven dawns before wrestling with the question, To what extent is health care a right?

I'm happy I was born in the mid-20th century rather than the mid-17th or 18th, at which time American society asked "Who deserves to be educated?" and answered, "Wealthy, white males." At some point the community

said, We need better answers than the ones we have. I guess I'm appealing that this side of the Apocalypse I think it's legitimate to ask, Is health care, no less than education, a right?

Caplan: It's always a pleasure to attempt damage control while the vessel is sailing forward.

One issue that has been raised is the responsibility of bioethicists or the press where there's an innovative medical experiment. Many people at Loma Linda feel that LLU came in for harsh and unfair criticism. That is not my impression. Many of the criticisms were raised in a conditionalized fashion! "If this is true, then that would be bad." That is not to say that no one in the bioethics community pronounced things that subsequently turned out to be factually false. Nor is it the case that everyone in the press adequately reported what took place.

But I don't think for a minute it is wrong to pay close attention to an innovative medical experiment when a child is involved. I also believe it's important to ask, "Is the scientific basis there?" and "How well was the informed consent handled?"

Let me, if I may, Alex, say a word about the issue of heaven and the classless society. I did say that it was not simply a matter of supply and demand because I gave you three criteria for committing resources: First, Does it work the way people who do it claim it works? Second, Do people want it? And third, I told you I didn't want it done or paid for, or resources allocated, if it distorted what was available to others. So I reject the idea that I'm simply giving a supply-and-demand analysis.

Let me come, finally, to the issue of cadavers. I still believe presumed consent is **ethically** acceptable. That is, if you could assure people the right to object, to opt out of a system in which people were presumed to be donors unless they or their family had an objection, that would be to me an ethically acceptable way to procure tissue. What made me change my mind about presumed consent was not the ethics but the practice. If someone can think of a way to do it practically, I have no objection to it.

Capron: One issue is sort of the flip side of what Dr. Caplan has mentioned. It would have been a lot easier for people in the position of Art Caplan who are called on to comment on something ethically, and it would also would have been easier for scientists called on by the press to give their views, if this case had come up in the normal processes of notice to the scientific community rather than being called on and having to say to the reporter, "You'll have to give me the details; I haven't read anything about it yet."

So that Arthur's kindness can be better understood, I'd like to read something and then give Dr. Bailey the closing minutes to respond to it. There was at least one critic who fully met Dr. Bailey's description—Professor George Annas of Boston University. In the Hastings Center **Report** he summed up his views by saying, "This inadequately-reviewed, inappropriately-consented-to, premature experiment on an impoverished terminally-ill newborn was unjustified." Because Arther has said such nice things this evening, I want to give you an opportunity to confront one of your more strident critics with anything you'd like to say.

Bailey: It does make you wonder to whom ethicists are accountable. Several months before Baby Fae, Magdi Yacoub, active in London, did a similar transplant in a baby. Where were all the ethicists when that was done? The only difference is that we used a cross-species transplant. He got a few bylines and that was the end. Because we crossed the species line we got all the publicity and the ethicists came out to greet us. I'd like to throw that back to Dr. Caplan. Where were you when Magdi Yacoub did the first newborn heart transplant, and why was ours wrong and his was right, when it was an abject failure scientifically? And without any experimental background, I might add.

Caplan: That does give me an opportunity to say something really saccharin. Nonetheless, I'm going to say it at the risk of leaving me with diabetes. It is this: we have a better system of human experimentation protection than the British do. What goes on in England, you would not want to take place here. I think the British human experimentation system is much more dependent on the discretion of the researcher. I think the regulations and committee review they operate under do not accord dignity and autonomy to subjects. I have problems with the British system and Dick Sheldon and I have argued about it over the years. I still think there should be tough review particularly where children are concerned. I'd rather have this system than their system. The reason you don't hear me bemoaning a transplant in England is that I think they're back in the 1950s with respect to medical ethics in the human experimentation area.

"It does make you wonder to whom ethicists are accountable." *Leonard Bailey*

Bailey: You may, of course, live to regret those statements.

Caplan: Where are the British?

Bailey: The British are coming!

Caplan: Well, I'm going there in July. We'll see.

Capron: You may not be able to get a visa!

Caplan: That's right!

Bailey: The one concept that I think has eluded our speaker tonight, and George Annas even more so, is the fact that the Baby Fae project is a rather natural extension of what I do every day. It is not very different from innovative things that are done each day in my operating room without IRB approval, or with IRB approval, simply by the nature of the diseases I deal with.

Capron: This has been extraordinarily interesting evening for me. Senator Albert Gore of Tennessee has said, "There are many lessons learned in the extraordinary attempt to save the life of Baby Fae, but one lesson stands above all the rest: the need for a new partnership between society and the medical profession to create a sustained dialogue about the increasingly difficult bioethical issues confronting us."

The creation of the Ethics Center here at Loma Linda which this symposium celebrates is one step. The existence of other centers, such as the Hastings Center in New York, is another step. I hope you all will continue to give your interest and support so that those who are on this panel who are physicians, like those of us who are concerned citizens, will have means for discussing these important issues.

Thank you all for coming.

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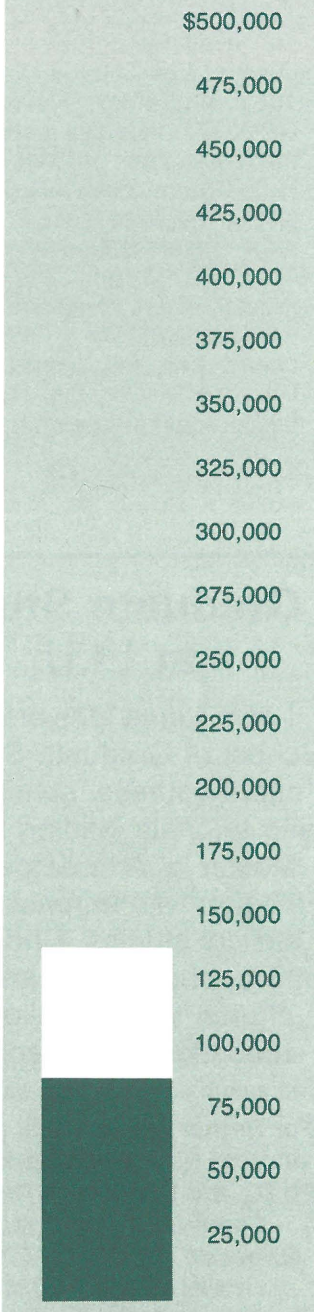

AUDIO CASSETTES AVAILABLE

Audio cassettes of the presentations at "Biomedical Ethics Today: Old Models and New" are available for a modest charge from Study Tapes, 1341 Pine Knoll, Redlands, CA 92373. Video cassettes of the discussions of "What's A Little Church Like Ours Doing in Big Medicine Like This?" and "Ethical Issues in Organ Transplantation: Human, Animal, and Artificial Organs" are available for a modest charge from the Loma Linda University Church, Loma Linda, California 92350.

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DO CANCER PATIENTS EXPECT TOO MUCH?

"My doctor doesn't talk to me."
"My doctor has abandoned me."
"My doctor says I have psychological problems when I complain about my disease, and I feel hopeless and helpless to do anything about it."

Such are the sentiments of cancer patients, according to Stephen R. Harrison, a University of California at Los Angeles psychiatric resident who has specialized in the physician/cancer-patient relationship. Harrison was one of four panelists who led the May 8 Medicine and Society Conference, a monthly session held in a LLU Medical Center amphitheater.

Panelist Diana Champ, 31, with stage IV ovarian cancer, detailed good and bad experiences with physicians. Her present physician, found through personal diligence, she says, "treats me as a person and not just as a disease."

Oncologist Irvin Kuhn, a professor of internal medicine at Loma Linda, agreed with the ideal: an oncologist who possesses great sensitivity and insight plus a high degree of medical expertise. However, he questioned the excessively high expectations some have for the oncologist/patient relationship. "The innate physician personality means that doctors are more the egghead than the salesman type. This is especially true of the internist; after years of acquiring the needed medical knowledge, there is little time or energy left also to master interpersonal relationships." Panelist Kuhn also indicated that patient personalities range from the "eternally optimistic to the infernally depressed." It is difficult for the medically-trained physician to know precisely how to deal with such a variety of mental stress. "A meaningful doctor/patient relationship," said Kuhn, "is dependent on the coming together of various factors: educational level, patient gender, marital status, family support, and financial status."

Mary Hoban, an oncological nurse who lectures at U.C.L.A.'s School of Nursing, told the store of a busy and personable oncologist: "He always walked in and pulled up a chair and sat down by the patient. Sometimes he didn't sit but 30 seconds. He always asked the patient how he was, and at some point in the conversation touched the patient. Invariably his parting words were, 'I'll see you tomorrow.' " These small gestures, according to Hoban, "made all the difference in the world."

Brief statements by the panelists were followed by audience comments and questions. One member of the audience regretted the lack of time to explore thoroughly the differing perspectives, but was pleased that "at least the various professionals are talking to each other."

The Medicine and Society Conferences are held on the second Wednesday of each month during the regular school year at noon in the A-level amphitheater of the LLU Medical Center. The public is invited, and there is no fee. The conferences are jointly sponsored by the Ethics Center and the LLU School of Medicine. The Wuchenich Foundation provides total funding.

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